State of New York
WORKERS' COMPENSATION BOARD

REQUEST FOR FURTHER ACTION BY INSURER/EMPLOYER

This form is submitted by ☐ insurer ☐ self-insurer ☐ Special Funds Group

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS

1. WCB CASE NO.	2. CLAIM ADMIN CLAIM NUMBER	3. INSURER CODE	4. DATE OF INJURY (MM/DD/YY)
		W	/ /

	NAME	ADDRESS TO WHICH NOTICES SHOULD BE SENT
5. CLAIMANT		Check if new address: ☐ APT. NO.
6. EMPLOYER		
7. INSURER		
8. ATTORNEY / LICENSED REP.		ATTY/REP ID NO. R

9. **INSTRUCTIONS:** The insurer/employer seeks Board action regarding the claim identified above for the following reasons (**check all that apply**). Please note that the **required documentation** identified below **must be attached** to the form and submitted to the Board or **must be referenced** in the space provided below** (by date, name or title of document, and form ID) if it is already in the Board's electronic file. This form must be submitted to the Workers' Compensation Board by mail, email or Web Upload. Information can be found on the Forms page of the Board's website. A copy of this form and the attachments must be sent to the claimant and claimant's representative if one has been retained. A copy of this form and the attachments must also be sent to the health care provider if item a or b is checked.

Compensation:

☐ a. Continuing payments directed by the Board should be suspended as of _____ pursuant to 12 NYCRR 300.23(b). *(medical or payroll documentation supporting suspension required)*

☐ b. Continuing payments directed by the Board should be reduced to _____/wk as of _____ pursuant to 12 NYCRR 300.23(b). *(medical or payroll documentation supporting reduction required)*

☐ c. Payments should be modified as claimant is working at full or reduced earnings as of _____. *(payroll documentation supporting modification required)*

☐ d. Payments should be suspended as of _____ as claimant has voluntarily removed themself from or is no longer attached to the labor market. *(documentation supporting suspension required)*

☐ e. Payments should be suspended as of _____ because of disqualification pursuant to WCL § 114-a. *(list of documents or evidence to be produced required)*

Medical Issues:

☐ f. Claimant's disability is now amenable to a facial award or schedule loss of use award. *(medical documentation indicating permanency required)*

☐ g. Claimant's disability is now amenable to a non-schedule award. *(medical documentation indicating permanency required)*

☐ h. Claimant has made an application to reopen a previously established claim seeking additional benefits, and pursuant to 12 NYCRR 300.22 the insurer contends _____
(statement as to the insurer's position on the payment of further benefits required)

☐ i. Opioid Weaning under Non-Acute Pain Guidelines. *(medical documentation indicating weaning goals and recommended weaning program/resource is required)*

☐ j. Request denial of future treatment that insurer contends is not related to an established site or condition
(insurer must state what treatment is not related, and why)

_____

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Other:

☐ k. Parties have entered into a stipulation. (*Form C-300.5 or written stipulation required)*

☐ l. Parties have reached an agreement and seek a Proposed Conciliation Decision. (*Form C-312.5 or proposed findings required)*

☐ m. Claimant has discontinued or settled a lawsuit pertaining to the accident/injury of this claim. *(documents indicating discontinuance, settlement, or closing statement required)*

☐ n. Insurer seeks desk review of Special Funds Group reimbursement decision *Form C-251.6R*. (*Form C-251.6R and all related forms and emails to and from SFG required per SN046-1063R. New evidence may not be submitted*)

☐ o. Insurer has new or requested documentation regarding _____ *(documents required)*

☐ p. Other. (Explain fully in space provided below.)

_____

****Document reference information (date, name/title, form ID):** _____

I certify that this request for Board action is based upon reasonable grounds, and that this form with attachment(s) has been provided to the opposing party(ies). I also certify that (check one box below):

☐ **I have discussed the issue(s) above with the opposing party(ies) or its representative(s).**

(give name of person contacted) _____ ***(on date)*** _____ **and that (check one):**

☐ no settlement of the issue(s) could be reached. ☐ settlement of the issue(s) was reached *(documentation required).*

☐ **I attempted to contact *(give name)*** _____ **(o*n date)*** _____

to discuss the issue(s) above, that I have waited a reasonable time for a response, but that no discussion was forthcoming.

CERTIFIED BY (Please Print Name)	WCB ID NO.	DATE PREPARED (MM/DD/YY)	AREA CODE	TELEPHONE NUMBER
		/ /		

Please note: Failure to check either the "I have discussed" or "I attempted to contact" boxes will result in no action on the RFA-2.

TO THE INSURER/EMPLOYER

This form may be filed by the insurance carrier or employer in a workers' compensation case when it wants the Workers' Compensation Board to take action in the case. ATTACH ALL APPLICABLE EVIDENCE FOR CONSIDERATION BY THE BOARD. A copy of this form and the attachments must also be sent to the claimant, and their representative, if any. If item a or b is checked, a copy of this form and the attachments must also be sent to the claimant's attending doctor. If you would like online access to the case, you can register for eCase using the registration instructions available on the Board website under the eCase link.

MTG Special Services or MTG Variance Prior Authorization - Decisions issued by the Medical Director's Office under 12 NYCRR Section 324.3(d)(6)] cannot be appealed by the carrier. Information regarding the Prior Authorization Request process can be found on the WCB website www.wcb.ny.gov.

Regarding Items a and b - Board Rule 12 NYCRR 300.23

This is to notify the Board of the insurer/employer's intention to reduce or suspend the claimant's payments in accordance with Board Rule 12 NYCRR 300.23. This notice may be filed in any case where there has been an award and a direction for continuation of payments and evidence is presented to support the suspension of payments or reduction in rate.

The Board, upon receipt of this notice and attachments, may either schedule a WC LAW JUDGE HEARING on this issue within 20 days during any period in which regular hearings are scheduled, or refer the matter to the Administrative Review Division for a determination of whether a reopening is warranted. In the event that the Administrative Review Division directs that the case be reopened, a WC Law Judge Hearing will be scheduled in an expeditious manner. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, THE CASE WILL NOT BE SCHEDULED FOR A HEARING.

Cases at hearing points which do not have regularly scheduled hearings within 20 days may be scheduled at another hearing point. At the time a WC Law Judge hearing is held, either immediately after the Board's receipt of this notice and attachments or at the direction of the Administrative Review Division, the WC Law Judge will consider all available evidence and decide whether or not payments may be suspended or reduced.

PAYMENTS SHALL CONTINUE, AS DIRECTED, until there is a determination by the WC Law Judge that such payments may be suspended or reduced.

TO THE CLAIMANT

If you have any questions regarding the action being requested by the insurer/employer, please contact the Board's **ADVOCATE FOR INJURED WORKERS at (877) 632-4996**. If you have retained legal counsel to represent you, you may contact them for assistance. Please remember to always use the WCB Case Number shown on the other side of this form when corresponding with the Board. If you would like to follow your claim online, you can register for eCase using the registration instructions available on the Board website under the eCase link.

AL RECLAMANTE

Si tiene alguna pregunta en relación a la acción solicitada por el patrono ó el seguro favor de **llamar al Defensor de los trabajadores lesionados (877) 632-4996.** Si está representado legalmente, debe comunicarse con sú representante para asesoramiento. Cuando se comunique con la Junta, siempre use el número de caso WCB que aparece en el otro lado de esta notificación. Si desea realizar un seguimiento en línea de su reclamo, puede registrarse para ingresar a eCase utilizando las instrucciones para registro que están disponibles en el sitio web de la WCB en el enlace eCase.

TO THE CLAIMANT - Regarding Items a and b

Please read this notice and attachments carefully. If item a or b is checked, this notice means that your employer (if self-insured) or its insurance company wants to suspend or reduce your compensation payments, for the reason indicated.

As explained above, your case may be scheduled for a hearing on this issue. Be sure to BE PRESENT, if you disagree with your employer or their insurance company. If you are NOT PRESENT, the W.C. Law Judge will make a decision based on available evidence. If your employer or their insurance company contends that your compensation payments should be suspended or reduced because your medical condition has improved (not because your earnings have increased), BRING TO YOUR HEARING THE MOST RECENT MEDICAL REPORT FROM YOUR DOCTOR THAT DESCRIBES YOUR CURRENT MEDICAL CONDITION.

PARA EL RECLAMANTE - Respecto de los puntos a y b

Lea atentamente esta notificación y los documentos adjuntos. Si están marcados los puntos a o b, esta notificación significa que el empleador (en caso de estar auto asegurado) o su compañía aseguradora, desea suspender o reducir los pagos de su indemnización, por el motivo que se indica.

Tal como se explica anteriormente, es posible que se fije una fecha para una audiencia sobre su caso en relación a este asunto. Asegúrese de ESTAR PRESENTE, en caso de que usted esté en desacuerdo con su empleador o su compañía aseguradora. Si usted NO ESTÁ PRESENTE, el juez que dirime sobre cuestiones laborales tomará una decisión a partir de la evidencia disponible. En caso de que su empleador o su compañía aseguradora aleguen que se deben suspender o reducir los pagos de su indemnización debido a una mejoría de su condición médica (no debido a un aumento de sus ingresos), PRESENTE EN LA AUDIENCIA EL INFORME MÉDICO MÁS RECIENTE QUE DESCRIBA SU CONDICIÓN MÉDICA ACTUAL, ESCRITO POR SU MÉDICO.

Section 114 of the Workers' Compensation Law provides, in part, that any employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who knowingly makes a false statement or representation as to a material fact for the purpose of avoiding provision of any payment or benefit under this chapter shall be guilty of a felony.

NEW YORK STATE | Workers' Compensation Board

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